

**ARKANSAS DEPARTMENT OF HIGHER EDUCATION**  
114 E. Capitol Little Rock, AR 72201  
501.371.2000 Fax 501.371.2001

**ARKANSAS HEALTH EDUCATION GRANT (ARHEG) PROGRAM**

**DENTAL LOAN FORGIVENESS VOUCHER**

Notice of Intent to Seek Loan Forgiveness for:

Loan Year: \_\_\_\_\_ Amount of Loan: \$ \_\_\_\_\_

**PLEASE PRINT OR TYPE**

NAME: \_\_\_\_\_ SSN \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_

COLLEGE OF DENTISTRY: \_\_\_\_\_

GRADUATION DATE: \_\_\_\_\_

AR LICENSE #: \_\_\_\_\_ DATE RECEIVED: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

SERVICE DATES (dd/mm/yyyy)

FROM: \_\_\_\_\_ TO: \_\_\_\_\_

(over)

**ARKANSAS DEPARTMENT OF HIGHER EDUCATION  
ARKANSAS HEALTH EDUCATION GRANT (ARHEG) PROGRAM  
DENTAL LOAN FORGIVENESS**

**The following Notarization of Affidavit must be signed in the presence of a commissioned notary public and affixed with his or her seal.**

**Notarization of Affidavit**

The undersigned, being first duly sworn upon his or her oath says that each and severally the answers and statements made above are true and correct to the best of his or her knowledge and belief.

By my signature, I attest that \_\_\_\_\_ has been in my employment for one (1) full year of uninterrupted service as required by the Agreement for **Loan Year 2003-04**.

Signature of Employer: \_\_\_\_\_

By my signature, I, \_\_\_\_\_, attest that the information I have provided is complete and correct, and that one (1) year of my loan is forgiven for one (1) year of uninterrupted service of dentistry to the State of Arkansas.

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature of Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_ 20\_\_\_\_\_